Medical educational: the development of intellect

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Competency based training looks to build the (key) skills, knowledge and attitude towards the discipline.[1] There is an emphasis on continuous professional development through lifelong learning, research and critical thinking. The evidence based medicine also looks to develop the critical reading and interpretation skills of the trainees so that they can cope with the ever-changing scene of medical — education.[2]

The fundamental focus of medical education is to define the tables of specifications, the curriculum outline and the teaching Rota's. The critical question to ask is: what is the fundamental philosophy of medical education? The purpose of this write-up is to encourage the readers to ponder on the philosophy of education and come-up with constructive formulations.

Science being a global phenomenon relies on the (unified) standards of training. Adherence to these standards brings recognition and worth (to the degree). Experimentation, without background training is perilous. However, recognized universities bring in measured change in the teaching methods and curriculum through discussions and dialogues. Ingenuity is encouraged and followed with audits and appraisals both from faculty and students. Stagnation brings in decadence and disinterest. It is not surprising to see the academic faculty in the recognized Universities to (co) author a book, as they move-up the ladder of professorship. Situation is grimmer in the context of Pakistan; lacking academic discourse, faculty is inundated with (clinical or administrative) services. Pakistan is greatly in need of training and trained people familiar with the concepts of medical education. There is a dire need of direction, objectives and life-long learning skills that enable individuals to seek new knowledge. In an increasingly technical and rapidly developing world, change is feared and not readily accepted especially by more traditionally trained medical faculty. In the words of Winston Churchill, "If we do not take change by the hand, it will surely take us by the throat."[3]

Observation tells us that knowledge is empowering, while (dogmatic) heresies are inauspicious. Should there be an educationalist in every department, supporting the curriculum needs, or a center of educational development should house such an individual(s). The former can devise the TOS's, curriculums and Rota's while encouraging creative introspection on the process of change. However, it is critically important to train the trainers in the nuances of medical education.

The fundamental World view of the discipline (only) comes from spending time in the clinical coal face (of practice). The term World view originates from the German word Weltanschauung (Welt- world: Anschauung; view or outlook).[4] It is fundamental to German philosophy. It refers to the framework of ideas and beliefs through which an individual, group or culture interprets the world and interacts with it. Training should look to develop and reinforce key skills and attitudes pertinent to the World view of the discipline. These should be passed on from the tutors to the disciples. As an example, epidemiology is very objective in approach, teasing out the biases and prejudices and psychiatry is very discursive in its outlook. Similar ethos exists within each specialty which is transferred by (sufficient) interaction between teachers and students.

Encouraging the personal statements and letter of intents are the initial steps, albeit small, in guiding individuals in defining their world view. Common outlooks bring individuals to a particular discipline and sharing of views reinforces the cognitive map. All of this happens at an unconscious level. However, in order to make it explicit, it is important to emphasize the psychological process operating behind it. Supervisors and clinical teachers need to be trained in encouraging these processes, through thoughtful discussions, practice and mentorship. It could very well be the ritual of physical examination in every patient; the teaching of clinical signs and symptoms on patient's bedside which has come down from generation of trainers. This is passed on to the new breed of doctors (equally equipped with palm top computer-gadgets and five minutes MD consults) or the art (and science) of arriving at the diagnosis.

Writing down the personal statement helps the individual focus his objectives. This can be helpful when commitment dwindles in challenging times. After all, training is supposed to challenge (and develop) the intellectual and emotional resources over the course of years. A thoughtfully written personal statement not only serves to define the focus but it also impresses the

supervisor, giving him the right message. Alternatively, a drab of a statement primes the supervisor regarding the deficits in the outlook of the trainee. The individual can be helped to develop skills in the weak areas.

While it is important to focus on the knowledge and skills within the sphere of the discipline, it is equally important to impart thinking skills. Audit of the practice and reflection on the behaviour will help to develop the flexibility of approach which is a prerequisite in ever changing landscape of medical education. Setting up specific time in a week in order to help develop these skills and define the focus of the training can be helpful in this regard. This can be an individual or a shared activity.

Diversity of training-requirement and complexity of skills require that trainees work under various supervisors in order to meet the expectations; gone are the times, when trainees use to work under one supervisor. Appreciation of this fact helps to make the learning curve easy for the under-graduate and post-graduate students alike. Coordination between the centers and individuals is a key assignment of the supervisor. Sometime this requires bridging personal differences with an individual in order to give access to (certain) patient population, procedures or expertise. Management skills are an important armament of the clinical supervisors.

Integration seems to be the buzz word in the current era of medical education. However, specialties and programmes lie on a continuum of the either (total) isolation to trans-disciplinary training approach.[4] Developing the training programme to fulfill the expectation of the licensing authorities and supervisory bodies is an important expectation. Trainees also need to be made aware of the expectations out of the individual rotations. This need to be made explicit with (assigned) reading material, assignments and outcomes in the form of a consolidated document. It's desirable to put such a document on the public domain in order to disseminate the key features of the training programme.

Assessments are an important part of every programme. It's best to pre-define the key skills and areas which will be assessed. This defines the goal post for the trainees. Assessments should be done in an impartial way. Blinding of assessors and objectivity of the whole process is central in keeping the faith in the system (so to speak). Assessment process should be efficient and transparent. Team of experts should have necessary discourse (and agreement) on the items of examination. It is important to carry out the post-hoc analysis and tease out a discriminatory index of particular items. In summary the key principles of adult learning should be considered when designing or implementing medical education. Putting the onus of learning on the trainees, helping them identify the training needs and gaps in their knowledge, providing the right culture to foster growth and inquiry is an important determinant of medical education.[6]

The fundamental philosophy of education has to be the development of intellect (al-'aql). It is apt to clarify the preference for the English word 'intellect' rather than 'reason' to translate the Urdu /Arabic word 'aql. A teacher should look to evoke the true meaning embodied in the Latin root word 'intellectus', practically identical to that of a nous in the Patristic Greek tradition: Intellectus/nous is that which is capable of a direct contemplative vision of transcendent realities, whereas reason - the translation of the Latin ratio and the Greek dianoia - is of an indirect, discursive nature. This later works with logic and arrives at mental concepts of those realities. With the intellect, one is able to contemplate the Absolute meaning of things while with the reason, one can only think about it.

References

1. Association of American Medical Colleges. Physicians for the Twenty-first Century: Report of the project panel on the General Professional Education of the Physicians and College Preparation for Medicine. J Med Edu 1984; 59: 1-208.
2. Besley J. What is evidence based medicine? London: Hayward Medical Communication, 2009.
3. Douglas K. Smith. Taking Charge of Change: Ten Principles for Managing People and Performance. Reading, MA: Addison-Wesley Publishing Company, 1996; pp 314.
4. Goodwin G. Mood disorder. In: Companion to psychiatric studies, sixth edition. Churchill Livingston: Harcourt Brace and Company Limited, Edinburgh, 1998; 551-64.
5. Harden M. The integration ladder: a tool for curriculum planning and evaluation. Med Edu 2000; 34: 551-7.
6. Kaufman DM. Applying educational theory in practice. BMJ 2003; 326: 213.
7. Shah-Kazmi- R. Justice and Remembrance- Ali.The Spirit of Intellect. I.B Tauris Publishers, London, 2007; pp 22.